STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120394-001**

Aetna Life Insurance Company
Respondent

Issued and entered
this 29th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 4, 2011, XXXXX, on behalf of her minor daughter XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health care benefits under a benefit plan underwritten by Aetna Life Insurance Company. The Commissioner reviewed the information and accepted the Petitioner's request on April 6, 2011.

The Commissioner notified Aetna of the external review request and asked for the information it used in making its adverse determination. The information was received on April 7, 2011.

The issue here can be decided by an analysis of the insurance certificate. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On July 9, 2010, Petitioner had a laryngoscopy performed by XXXXX, a XXXXX clinical assistant professor of pediatric otolaryngology. XXXXX has offices at the XXXXX in XXXXX and at XXXXX in XXXXX. The Petitioner's procedure was performed at the XXXXX facility.

XXXXX submitted two claims to Aetna: $166 for an office visit and $296 for outpatient surgery. The XXXXX also submitted a claim to Aetna for $318 for "hospital incidentals." Aetna processed the claims as described below:

PROVIDER	CHARGE	APPROVED AMOUNT	CO-PAY	DEDUCTIBLE	AETNA PAYS	PATIENT OBLIGATION
XXXXX	166.00	109.56	45.00	00.00	64.56	45.00
XXXXX	296.00	195.36	00.00	195.36	00.00	195.36
XXXXX	318.00	225.78	00.00	225.78	00.00	225.78
TOTALS	780.00	530.70	45.00	421.14	64.56	466.14

The Petitioner's mother appealed the claims processing and disputed the XXXXX charge for hospital incidentals. Aetna completed its internal grievance process and upheld its original denial, issuing its final adverse determination on February 23, 2011.

III. ISSUE

Did Aetna correctly process the claims for Petitioner's July 9, 2010, surgical procedure?

IV. ANALYSIS

Petitioner's Argument

In her request for external review, the Petitioner's mother wrote:

> I would like Aetna to recognize that the service provided in XXXXX's office at XXXXX was an office procedure and XXXXX is billing incorrectly based on service provided. Our copay should be $45.00, not an office deductible.

The Petitioner's mother provided a more detailed complaint in a January 17, 2011, appeal letter to Aetna:

> This claim was deemed to be part of our deductible. However, this was an OFFICE visit to see XXXXX, at which time he elected to conduct a test to help validate his decision. This was all done ***in*** office. XXXXX bills items as "hospital." This is not a valid claim, however, they refuse to change their billing. Under our health insurance contract, we have a $45.00 co-pay for specialist visits, as well as a $45.00 co-pay for in office surgery, which is exactly what this claim is being portrayed as. THIS WAS SURGERY DONE IN AN OFFICE, NOT AN

> OUTPATIENT IN A MAJOR HOSPITAL. JUST BECAUSE THIS DR. IS AFFILIATED WITH XXXXX DOESN'T MAKE THIS PROCEDURE DONE AT THE HOSPITAL.
>
> As far as the 2nd claim of $318.00 for "hospital incidentals," I find this to be incredibly ridiculous and deceiving. What do these incidentals include? SHE WASN'T IN THE HOSPITAL. I demand that XXXXX send an itemized list to Aetna and me so we can see what these are for. I don't know how Aetna can even make a determination on whether or not to pay the claim. Is it easier for Aetna to just put it to my deductible, hoping I won't question the claim, thereby resting the financial responsibility [with] me? I don't think so.
>
> I am sending this letter to both, XXXXX and Aetna, in hopes your two companies can work out the correct billing codes to get this to where it should be, at two $45.00 co-pays.

Respondent's Argument

In its final adverse determination dated February 23, 2011, Aetna wrote:

> Aetna received office visit charges for July 9, 2010 provided by XXXXX and this was paid correctly with a $45.00 copayment. The outpatient surgery charge by XXXXX was billed indicating the place of service was an outpatient hospital. Therefore, the charges were processed correctly with 80% after deductible. The charges from XXXXX were billed as outpatient surgery at an outpatient hospital setting. Therefore, the charges were processed according to 80% after deductible at a hospital and an ambulatory surgical center. We have contacted XXXXX's office and they are billing according to the services provided, Aetna processes the claim accordingly. Therefore, the Committee must adhere to the terms of your contract and your request to reprocess the claims has been denied.

Commissioner's Review

The petitioner does not challenge Aetna's processing of XXXXX's office visit claim. For that claim it was appropriate that Aetna assess a $45 copayment. No deductible was assessed for the office visit.

Outpatient surgery is processed under the policy provision which requires Aetna to pay 80% of the approved amount after the insured has met the deductible requirement. In this case, the deductible was $195.36, the full approved amount. Outpatient surgery is not the same as an office visit, subject only to a copayment. Aetna's processing of XXXXX's outpatient surgery claim was therefore correct.

The final issue involves the XXXXX charge for "hospital incidentals." In her request for review, the Petitioner's mother asserts that the XXXXX improperly billed for hospital medical services when her daughter had not been treated in a hospital. While the care in question was not provided in a hospital, it was performed at a XXXXX facility and therefore might reasonably be expected to be billed by XXXXX. However, this is a dispute with the medical provider. The Commissioner has no regulatory authority over the XXXXX medical facilities and, for that reason, cannot require the XXXXX to change its billing.

The Commissioner finds that Aetna processed the July 9, 2010, claims in a manner consistent with the terms of the petitioner's benefit plan.

V. ORDER

The Commissioner upholds Aetna's February 23, 2011, final adverse determination. Aetna is not responsible for any additional coverage for Petitioner's July 9, 2010, outpatient surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.